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**Issue Date: 16 November 2006**

In the Matter of

H.M., JR.,
Claimant

v.

APOGEE COAL CO.,
Employer

and

ARCH COAL, INC.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case No. 2004-BLA-06118

Appearances: Mark L. Ford, Esq.
For the Claimant

Denise M. Davidson, Esq.
For the Employer

Before: William S. Colwell
Administrative Law Judge

## DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, H.M., Jr. alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on August 2, 2005 in Harlan, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Administrative Law Judge's Exhibits("ALJX") 1-3, Director's Exhibits ("DX") 1-28, Employer's Exhibit ("EX") 1, and Claimant's Exhibits ("CX") 1-2 were admitted into evidence without objection. Transcript ("TR") at 6, 7, 9, 10. Employer was provided the opportunity to submit post-hearing evidence. TR 9-10. By Notice dated September 3, 2005, Employer submitted the deposition transcript and medical report of Dr. Thomas M. Jarboe, which had previously been identified and admitted into evidence as EX 1 at the hearing. The parties were afforded the opportunity to submit post-hearing briefs. Employer and Claimant both submitted briefs. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

## PROCEDURAL HISTORY

The Claimant filed his first application for benefits on March 13, 1985. DX 1. It was denied by the Office of Workers' Compensation Programs on September 6, 1985, based on a finding that Claimant had failed to establish the existence of pneumoconiosis arising out of coal mine employment or total disability due thereto. DX 1. Claimant did not appeal that decision, however, on September 30, 2002, he filed his second application for benefits. DX 3. The District Director issued a Proposed Decision and Order denying benefits on December 17, 2003, and Claimant filed a timely request for a hearing. DX 23, 25.

## APPLICABLE STANDARDS

Since this claim was filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose at least in part out of his coal mine employment, that he is totally disabled, and that the pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays interpretations, the results of no more than two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. §725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and

physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. Id. In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. §725.414(a)(2)(ii). Likewise, employers and the District Director are subject to identical limitations on affirmative and rebuttal evidence. §725.414(a)(3)(i, iii).

## ISSUES

After the hearing, the following are the remaining contested issues:[1]

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes a material change in condition pursuant to 20 C.F.R. §725.309.

DX 28.

The Employer also reserved its right to challenge the statute and regulations. These issues are beyond the authority of the administrative law judge and are preserved for appeal purposes only. TR 5.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Factual Background and the Claimant's Testimony

The Claimant testified to the following. TR 11-25. He was 78 years of age at the time of the hearing. He last worked as a coal miner in 1984, having started his coal mine employment for U.S. Steel in 1946. He shot coal, ran machinery, drilled top, worked haulage and was a miner helper. His last coal mine work was as a motor man. Claimant uses an inhaler and has problems with coughing and choking. Claimant stated that he smoked cigarettes until 1972, having started smoking in 1954. Claimant suffers from ulcers. He does not believe he has the wind to return to his prior coal mine work.

[1] Employer concedes that it is the responsible operator and that Claimant has established thirty-eight years of coal mine employment. TR 5, DX 28.

Subsequent Claim

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. Claimant's first claim was denied in 1985. The instant claim was filed in 2002, not within one year of the prior denial. It is, therefore, a subsequent claim and I must consider the new evidence to determine whether the Claimant has proven at least one of the elements of entitlement previously decided against him. If he has, then I must consider whether all of the evidence establishes that he is entitled to benefits.

The United States Court of Appeals for the Sixth Circuit, under whose jurisdiction this claim arises,[2] has articulated the standard to be followed in determining whether the requirements of Section 725.309 have been met. Thus, in *Sharondale Corp. v. Ross*, 42 F. 3d 993 (6th Cir. 1994), the Court stated:

> . . . to assess whether a material change in condition is established, the [administrative law judge] must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the [administrative law judge] must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

*Ross* at 997-998.

The purpose of §725.309(d) is not to allow a claimant to revisit an earlier denial of benefits, but rather to show that his condition has materially changed since the earlier denial.

In applying the provision of §725.309(d) and in attempting to determine whether a material change in condition has occurred, it is necessary to evaluate only the new evidence offered to determine if the Claimant has satisfied at least one element previously adjudicated against him required in establishing entitlement. Since the prior claim was denied on the basis that the Claimant failed to establish the existence of coal workers' pneumoconiosis or total disability due to pneumoconiosis, I will initially determine whether the evidence submitted since that prior denial now establishes any of these elements of entitlement. If one is established, then all record evidence must be weighed to determine if the Claimant has established all elements on the merits. Otherwise, the instant claim must be denied.

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[2] The Benefits Review board has held that the law of the circuit in which the Claimant's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989) The Claimant's last coal mine employment took place in Kentucky, which falls under the Sixth Circuit's jurisdiction.

## Medical Evidence

### Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).[3] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

[3]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of ] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

| Date of X-ray | Readers' Qualifications (all are doctors) | Reading and Film Quality | Result Concerning Presence of Pneumoconiosis |
|---|---|---|---|
| DX 9<br>10/31/02 | Baker<br>B | Quality 2 | t/s 1/0 |
| DX 9<br>10/31/02 | Goldstein<br>B | Quality 3 | Used by District Director for quality reading only |
| DX 10<br>10/31/02 | Wiot<br>B BCR | Quality 2 | No pneumo |
| DX 10<br>1/14/03 | Wiot<br>B BCR | Quality 3 | No pneumo |
| DX 12<br>1/14/03 | Hudson[4] | Not noted | No pneumo |
| DX 13<br>1/14/03 | Jarboe<br>B | Quality 3 | No pneumo |
| CX 1<br>1/14/03 | Alexander<br>B BCR | Quality 3 | p/p 1/0 |

Under the "Other Comments" section of the x-ray report form, Dr. Goldstein listed "? cardiomegaly." DX 9. He also noted abnormalities of cardiac size or shape. In his report regarding the October 31, 2002 x-ray, Dr. Wiot found that there was a dilation of the innominate artery on the right and that the chest was otherwise unremarkable. DX 10. On the January 14, 2003 x-ray, Dr. Wiot commented on the heart size. DX 10. Dr. Alexander also commented on cardiac enlargement after reading that x-ray, as well as left ventricular prominence. CX 1. Dr. Jarboe found evidence of prominence of the left ventricle, compatible with hypertensive cardiovascular disease. DX 13.

It is to be noted that both parties list, in their respective briefs and Evidence Summary forms, an x-ray reading by Dr. Alexander of the October 31, 2002 x-ray, Employer labeling it as CX 1. Claimant's exhibit 1 is Dr. Alexander's reading of the January 14, 2003 x-ray. Claimant's exhibit 2 is the deposition testimony of Dr. Baker, and there are no other Claimant's exhibits. In sum, the record does not contain a reading by Dr. Alexander of the October 31, 2002 x-ray. As noted, below, however, were it in the record, it would not change the outcome.

Pulmonary Function Test

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. If there is greater resistance to the flow of air, there is more severe lung impairment. The studies

[4] Dr. Hudson testified to his findings regarding the January 14, 2003 x-ray in his deposition taken on July 31, 2003. DX 12. As that reading exceeds the limitations on the submission of evidence, it will not be considered herein.

range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second ($FEV_1$) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 and Appendix B. The following chart summarizes the results of the PFTs available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary test, the $FEV_1$ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the $FEV_1$/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i).

| Ex. No.<br>Test Date<br>Physician | Age<br>Height | $FEV_1$<br>Pre-/<br>Post | FVC<br>Pre-/<br>Post | MVV<br>Pre-/<br>Post | Qualify? |
|---|---|---|---|---|---|
| DX 9<br>10/31/02<br>Baker | 75<br>73.25 | 1.53 | 2.60 | | Yes |

Dr. Baker noted fair cooperation and comprehension on the study he conducted. DX 9. He also concluded that it was indicative of a moderate obstructive defect. Dr. John A. Michos, who is board-certified in internal medicine and pulmonary disease, found that study to be valid. DX 9.

By report dated August 18, 2005, Dr. Jarboe stated that he had reviewed the pulmonary function studies dated April 24, 1985 and July 18, 1985 and had compared them to the studies conducted on October 31, 2002. EX 1. In his opinion, there had not been a change in Claimant's pulmonary condition. He based this conclusion on the FVC values obtained. While the studies showed a fall in the FEV1, he found this to be the result of the natural aging process.

Arterial Blood Gas Studies

Arterial blood gas (ABG) studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen ($PO_2$) and the percentage of carbon dioxide ($PCO_2$) in the blood. A lower level of oxygen ($O_2$) compared to carbon dioxide ($CO_2$) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 CFR § 718.105. The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically not advisable. 20 CFR § 718.105(b).

| Exhibit Number | Date | Physician | $PCO_2$ at rest/ exercise | $PO_2$ at rest/ exercise | Qualify? |
|---|---|---|---|---|---|
| DX 9 | 10/31/02 | Baker | 39 | 69 | No |
| DX 12 | 1/14/03 | Hudson | 38.6 | 75 | No |

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis is a substantially contributing cause of the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 CFR § 718.201. See 20 CFR § 718.202(a)(4). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4).

Where total disability can not be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2). Quality standards for reports of physical examinations are found at 20 CFR § 718.104. The record contains the following medical opinions relating to this case.

Dr. Glen Baker (Examination on behalf of OWCP)

On October 31, 2002, Dr. Baker examined the Claimant on behalf of the Department of Labor. DX 9. Dr. Baker is board certified in internal medicine and pulmonary diseases. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, pulmonary function testing and electrocardiogram. He recorded that Claimant smoked cigarettes at the rate of a pack per day until 1972, with no start date being listed, although he did note that Claimant had a smoking history of fifteen years. Coal mine employment underground for 38 years was listed. Based upon his examination, Dr. Baker diagnosed (1) coal workers' pneumoconiosis 1/0: abnormal chest x-ray & coal dust exposure; (2) COPD with moderate obstructive defect: PFTS; (3) hypoxemia: PO2; (4) chest pain by history;

and (5) abnormal chest x-ray. He found the first three conditions to be due to coal dust exposure, with conditions 2 and 3 also being due to cigarette smoking. He was uncertain of the etiology of conditions 4 and 5. When questioned regarding the degree of impairment, Dr. Baker found a moderate impairment, noting Claimant's decreased FEV1, decreased PO2 and coal workers' pneumoconiosis 1/0. In his opinion, Claimant did not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment, citing as rationale "FEV1 43%."

The deposition testimony of Dr. Baker was taken on July 25, 2005. CX 2. Dr. Baker reviewed his examination of the Claimant as set forth above. He testified that Claimant related having smoked cigarettes for fifteen years ending in 1972. Dr. Baker stated that he believed that the pulmonary function testing he performed was valid and revealed a restrictive component. The blood gas study revealed some arterial hypoxemia. Dr. Baker explained that he attributed Claimant's moderate obstructive pulmonary defect to Claimant's history of coal dust exposure because of the two potential causes, smoking and coal dust exposure, he thought "probably the most significant cause was his coal dust exposure but the fifteen (15) pack year history of smoking may have contributed to some extent." In his opinion, Claimant would have a little difficulty doing his work as a driller and motor man, because of his breathing capacity. When questioned further, he stated that Claimant would be unable to do medium or heavy manual labor all day long.

Dr. Baker stated that Claimant was overweight, which condition can aggravate symptoms such as shortness of breath. Claimant had also indicated he had pneumonia on two different occasions, which illness can result in residual scarring of the lungs. While scarring can be confused with black lung, Dr. Baker stated that it was not likely that the changes he saw on the x-ray he read would have been caused by Claimant's prior pneumonias.

Dr. Arnold R. Hudson, Jr.

The deposition testimony of Dr. Hudson was taken on July 31, 2003. DX 12. Dr. Hudson is board-certified in internal medicine and pulmonary disease. He stated that he had the opportunity to examine Claimant on January 14, 2003. He performed a comprehensive examination of Claimant, taking histories, chest x-ray, blood gases, and a breathing test. Dr. Hudson stated that he was unable to get Claimant to cooperate adequately for the pulmonary function testing and that the testing was invalid. Upon examining the chest and respiratory system, Dr. Hudson noted that "[e]xpansion seemed somewhat limited. Difficult to tell if this is a problem with weakness or effort." As noted previously, while exceeding the limitation on evidence, Dr. Hudson did relate his reading of the chest x-ray taken as a part of his examination.

Based upon his examination, Dr. Hudson found that Claimant did not suffer from a chronic lung disease caused in whole or in part by his coal mine employment. He concluded that Claimant did not suffer from coal workers' pneumoconiosis. When questioned with regard to any need for treatment Claimant might have as a result of an

occupationally related condition, Dr. Hudson explained that, based on his measurements, he did not know to what extent Claimant had an obstructive airway disease and could not state "with certainty that he doesn't need treatment."

Dr. Thomas M. Jarboe

Dr. Jarboe submitted a report dated May 18, 2003, after his review of the x-ray readings of Dr. Wiot, and the medical reports of Drs. Hudson and Baker. DX 11. Dr. Jarboe reported that Dr. Hudson diagnosed COPD as evidenced by hyperinflation on chest x-ray and small airway obstruction on PFTs, and that Dr. Hudson found insufficient evidence to support a claim for a mining related lung injury, as Dr. Hudson felt that the reduction in forced vital capacity was most likely effort-related or due to underlying neuromuscular weakness. According to Dr. Jarboe, Dr. Hudson did find Claimant's numbers as recorded to be indicative of total disability. Dr. Baker found coal workers' pneumoconiosis, and his pulmonary function testing was valid.

Based upon his review of the evidence, Dr. Jarboe opined that coal workers' pneumoconiosis was not present. While Claimant appeared to have a moderately severe respiratory impairment and he did not appear to retain the functional capacity to do his last coal mine work, Dr. Jarboe found this impairment to be the result of cigarette smoking and not coal dust inhalation. Dr. Jarboe based this conclusion on the finding that Claimant had a hyperinflated chest on x-ray, which led him to the conclusion that Claimant's reduced vital capacity was due to air trapping and did not represent a true restrictive ventilatory defect. Dr. Jarboe noted that it was unfortunate that no lung volumes were ever obtained "to help sort this out." Dr. Jarboe pointed out that hyperinflation to this degree would rarely be caused by coal dust inhalation in the absence of obvious dust retention on chest radiograph. On the other hand, cigarette smoking "is by far the most common cause of hyperinflation of the lungs which is due to COPD/pulmonary emphysema." Therefore, according to Dr. Jarboe, cigarette smoking was the most likely explanation for the functional abnormalities seen in the Claimant. Dr. Jarboe also concluded that there was no radiographic evidence of pneumoconiosis, noting that Drs. Hudson and Wiot found the evidence to be negative while Dr. Baker read the x-ray as showing 1/0 pneumoconiosis. According to Dr. Jarboe, "[t]his of course means that he considered a negative diagnosis." Dr. Jarboe then concluded that the weight of the evidence was against coal workers' pneumoconiosis.

The deposition testimony of Dr. Jarboe was taken on August 14, 2003. DX 13. Dr. Jarboe testified that he is board-certified in internal medicine and pulmonary disease. During his deposition, he reiterated his opinion regarding the pulmonary function testing and the fact that the reduction in vital capacity would be very unlikely due to a true restrictive disease since Claimant's chest appeared hyperinflated. In such a case, the condition was more likely to be due to air trapping, which was due to COPD and emphysema. In his opinion, the Claimant's condition was the result of cigarette smoking. While pneumoconiosis can cause emphysema, usually it is in proportion to the amount of dust deposited in the lung and here, Claimant's film was read as negative for pneumoconiosis.

The deposition of Dr. Jarboe was taken again on August 18, 2005. EX 1. Dr. Jarboe testified that he had had the opportunity to review additional medical evidence, including the deposition testimony of Dr. Baker. He stated his disagreement with Dr. Baker's opinion. While Dr. Jarboe agreed that Claimant had a respiratory/pulmonary impairment and a moderate to severe impairment, he disagreed as to its etiology. Dr. Jarboe noted that Claimant had a smoking history of fifteen years, which, if it ended in 1972 as stated, then Claimant commenced smoking at the age of thirty years, which was "a bit of an unusual time to start smoking cigarettes." According to Dr. Jarboe, even assuming the smoking history obtained by Dr. Baker to be correct, that smoking history, in a susceptible person, would be significant. Dr. Jarboe stated that he had reviewed the pulmonary function testing performed in 1985 by Dr. Dahhan and that these were significant, because Dr. Dahhan's studies included total lung capacity values, and those were normal. This being the case, it indicated that Claimant did not have a true restrictive disease. This was further supported by the absence of evidence of dust retention in the x-ray evidence.

According to Dr. Jarboe, the presence of significant emphysema and the absence of dust retention on the x-ray indicated that the cause of the pulmonary condition was smoking and not coal dust inhalation. Comparing the pulmonary function testing conducted by Dr. Dahhan in 1985 with that conducted by Dr. Baker in 2002, Dr. Jarboe found the results to be quite similar, and in fact, showed no change, when one took into account the aging process. There had not been a significant change in Claimant's condition. Dr. Jarboe opined that the studies conducted by Dr. Baker were valid, however, contrary to the opinion reached by Dr. Baker, Dr. Jarboe did not believe that these studies were indicative of a restrictive impairment. Even taking into consideration the definition of legal pneumoconiosis, Claimant did not have pneumoconiosis.

## DISCUSSION AND APPLICABLE LAW

### Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or “clinical”, pneumoconiosis and statutory, or “legal”, pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition

includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201.

20 CFR § 718.202(a) provides that a finding of the existence of pneumoconiosis may be based on evidence from a (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions (not applicable here) described in Sections 718.304, 718.305, or 718.306, or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In order to determine whether the evidence establishes the existence of pneumoconiosis, I must consider the chest x-rays and medical opinions – the two categories of evidence applicable in this case. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 718.202(a). *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The record contains two x-rays read for the purposes of classifying pneumoconiosis. The October 31, 2002 x-ray was read as positive by Dr. Baker , a B-reader, while Dr. Wiot a B-reader and board-certified radiologist, found it to be negative. Similarly, the January 14, 2003 x-ray was read as negative by Drs. Jarboe and Wiot, while Dr. Alexander found it to be positive for pneumoconiosis. As the reading rendered by Dr. Hudson in his medical report exceeds the limitation on evidence as set forth in the regulations, it will not be considered herein. Dr. Alexander is a B-reader and board-certified radiologist.

For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2004); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991).

Readers who are board-certified radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52. Finally, a radiologist's academic teaching credentials in the field of radiology may be relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See Worhach v. Director*, *OWCP*, 17 B.L.R. 1-105, 1-108 (1993).

In this case, I find the reading by Dr. Wiot of the October 31, 2002 x-ray outweighs that of Dr. Baker, given the former physician's superior credentials. I further find that the reading by Dr. Jarboe, a B-reader, when coupled with that of Dr. Wiot, a B-reader and board-certified radiologist outweighs the positive reading rendered by Dr. Alexander of the January 14, 2003 x-ray. At best, the readings of the x-ray evidence could be seen to be in equipoise and therefore insufficient to meet Claimant's burden of proof.[5] Based upon the preponderance of negative readings by the more highly qualified physicians, I find that the x-ray evidence does not support a finding of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1).

[5] This would be the case had the reading of the October 31, 2002 x-ray by Dr. Alexander been in the record.

Analysis of Medical Opinion Evidence

I must next consider the medical opinion evidence of record. The Claimant can establish that he suffers from pneumoconiosis by a well-reasoned, well-documented medical report. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

To be considered are the medical opinions of Drs. Baker, Jarboe and Hudson. All are pulmonary specialists. Dr. Baker finds pneumoconiosis, stating his reliance on the Claimant's chest x-ray and his history of coal mine dust exposure. He goes on to diagnose COPD and hypoxemia, which he finds to be due to coal dust exposure and cigarette smoking. In his deposition, he explained that he reached this conclusion given Claimant's exposure to both tobacco and coal dust for an extended period of years. By contrast, Drs. Hudson and Jarboe found pneumoconiosis to be absent. Dr. Hudson stated the pulmonary function testing he conducted was not valid due to the inability to obtain sufficient cooperation from Claimant during the testing. While he opined that Claimant did not suffer from pneumoconiosis, he also stated he was unable to state to what extent Claimant had an obstructive airway disease or whether Claimant was in need of respiratory treatment. He found the absence of a chronic lung disease caused in whole or in part by coal mine employment; however, given his inability to render an opinion with regard to any obstructive airway disease suffered by the miner, I do not find credible his ability to rule out any such impairment being present or its etiology. In this respect, I find his opinion worthy of less weight than that of Dr. Baker and in so finding would also note that Dr. Baker had the benefit of a valid pulmonary function in rendering his opinion, an advantage which Dr. Hudson did not have.

Dr. Jarboe reviewed the medical evidence and determined that pneumoconiosis was absent. In his opinion, Claimant suffered from air trapping which was due to COPD and emphysema, both of which were caused by cigarette smoking. While Dr. Jarboe

agreed with Dr. Baker, in that Claimant suffered from a mild to moderate respiratory impairment, in his opinion, that impairment was the result of tobacco abuse and not inhalation of coal mine dust. In support of his conclusion, Dr. Jarboe pointed to Dr. Hudson's finding on chest x-ray of a hyperinflated chest, which finding the record, in fact, lacks. Furthermore, Dr. Hudson did not testify to that condition in his deposition testimony. I do not find Dr. Jarboe's opinion on this issue particularly credible, particularly in light of his statement that the x-ray reading of 1/0 by Dr. Baker indicated a negative reading. When reviewing the totality of the medical report and deposition evidence of Dr. Jarboe, I do not find his opinion sufficiently reasoned to rule out the possibility of legal pneumoconiosis. I also do not find Dr. Jarboe's explanation for ruling out coal mine dust exposure as a factor in Claimant's pulmonary condition to be persuasive in light of the fact that Claimant last smoked cigarettes in 1972 while he last worked in the nation's coal mines in the 1980s. Dr. Jarboe's heavy reliance on Claimant's smoking history, which was less than half the number of years spent in coal mining, is not persuasive on this issue. I find the report of Dr. Baker to be better reasoned on this issue. Dr. Jarboe did not have the benefit of examining Claimant, while Dr. Baker did. Dr. Jarboe relies on a medical report and objective testing which is not in the record, that being the report of Dr. Hudson. While Dr. Jarboe discusses at length the findings of hyerinflation and air trapping as found by Dr. Hudson, Dr. Hudson's testimony did not discuss these findings. I accord the opinion of Dr. Jarboe less weight than that of Dr. Baker.

Dr. Baker diagnoses coal workers' pneumoconiosis, based upon his own reading of a chest x-ray and the Claimant's history of dust exposure in his written report and discusses his findings and rationale in greater detail in his deposition testimony. Based upon his medical opinion, which is supported by the pulmonary function testing, I find that pneumoconiosis has been established pursuant to 20 CFR §718.202(a)(4). Accordingly, when weighing the medical evidence, I find that the medical opinion of Dr. Baker is sufficient to establish the existence of pneumoconiosis pursuant to 20 CFR §718.204, and in this respect, outweighs the contrary medical evidence of record.

As Claimant has established an element of entitlement previously adjudicated against him, all evidence of record must be reviewed. Accordingly, the evidence submitted with the prior claim will be discussed. That evidence includes readings of an x-ray dated April 24, 1985 by Dr. Simmons a board-certified B-reader, who found that x-ray to be positive for pneumoconiosis p/s 1/1, while Drs. Elmer and Sargent, who are similarly qualified, read that x-ray as negative. DX 1.

Dr. A. Dahhan, who is board-certified in internal medicine and pulmonary disease, examined Claimant on April 24, 1985. DX 1. He recorded that Claimant stopped smoking cigarettes in 1971, having smoked a pack per day in the past. Dr. Dahhan noted that Claimant quit smoking fourteen years ago, having started smoking at the age of fifty-five, which is obviously a typographical error inasmuch as the miner was 57 years of age at the time of the examination. Dr. Dahhan also recorded that Claimant had thirty-seven years of coal mine employment. Based upon his examination, which included the taking of a chest x-ray, blood gas studies and

pulmonary function testing, Dr. Dahhan diagnosed bronchitis, etiology of which was unclear, as well as tuberculosis of the stomach. He found the bronchitis not to be related to coal mine dust exposure, also diagnosing hypertension with hypertensive cardiovascular disease. Dr. Dahhan found that Claimant's pulmonary function testing suggested restrictive defect with mild impairment in his blood gas exchange mechanism at rest, normal after exercise. He suggested further pulmonary evaluation, i.e., lung volumes and diffusion studies before a final judgment regarding ventilatory status was established. Blood gas studies failed to produce values indicative of total disability. The ventilatory function testing conducted during that examination produced values indicative of total disability (FEV1 –2.15; FVC –2.6; MVV –90). The pulmonary function study was found to be valid by Dr. Kraman.

Dr. Dahhan submitted a second report on July 21, 1985, after an examination conducted on July 18, 1985. DX 1. Claimant was reported to have smoked a pack of cigarettes per day beginning at the age of twenty-five years and having quit fourteen years ago. Examination of the chest showed good air entry to both lungs, no crepitations or wheezings were detected. The chest x-ray showed simple pneumoconiosis, p/s 1/1. Blood gas studies showed minimal hypoxia at rest. The spirometry showed no evidence of airway obstruction. Lung measurement showed a mixture of air trapping and overinflation with added restrictive defect as indicated by the increased residual volume and reduced total lung capacity. Diffusion studies showed severe defect due to loss of volume. Based upon his examination, Dr. Dahhan concluded that Claimant had severe ventilatory impairment due to a combination of obesity, hypertension requiring therapy with beta blocker which causes air trapping as well as simple occupational pneumoconiosis. Blood gases at rest showed minimal impairment which became more pronounced after exercise. Based on the available findings, Dr. Dahhan stated that Claimant was not able to return to his prior coal mine work due to his respiratory insufficiency, resulting from obesity, hypertension, cardiovascular disease and simple occupational pneumoconiosis. Dr. Dahhan concluded that Claimant had smoked a pack daily for twenty years and noted that "the effect of that is difficult to access from the other contributing factors." With the report is a reading by Dr. Simmons of a July 18, 1985 x-ray, which reading was p/s 1/1. The blood gas study failed to produce values indicative of total disability. The pulmonary function study produced values indicative of total disability (FEV1 – 2.1/2.15; FVC 2.6/2.6; MVV 96/102).

Upon weighing the x-ray evidence and the medical reports submitted with the 1985 claim, I find the reports of Drs. Dahhan and the x-ray readings by Drs. Dahhan and Simmons support the finding of pneumoconiosis. I find that the totality of the evidence, new and old, supports a finding of pneumoconiosis.

Arising Out of Coal Mine Employment

Next, the Claimant must establish that his pneumoconiosis arose, at least in part out of coal mine employment. *See* §718.203 (a). It is presumed that pneumoconiosis of a Claimant who establishes ten or more years of coal mine employment arose out of

coal mine employment. *Id*. As the Employer in this case stipulated to coal mine employment of thirty-eight years, I find that the Claimant's pneumoconiosis arose out of coal mine employment. I further find that the evidence is insufficient to rebut this presumption.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment. 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2004). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2004). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2004); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas tests, and medical opinions.

Pulmonary Function Tests

All of the pulmonary function testing of record, from 1985 and 2002 produced findings indicative of total disability. Therefore, total disability has been established pursuant to 20 C.F.R. §718.204(b)(2)(i).

Arterial Blood Gas Studies

None of the arterial blood gas studies of record produced values indicative of total disability. Therefore, total disability has not been established pursuant to 20 C.F.R. §718.204(b)(2)(ii).

Medical Opinions

Dr. Baker in 2002 and Dr. Dahhan in 1985 found Claimant to be disabled, due at least in part, to coal workers' pneumoconiosis. Dr. Hudson found coal workers' pneumoconiosis to be absent, indicating, however, that he could not assess to what extent Claimant suffered from an obstructive airway disease. Therefore, his opinion is of little assistance on this issue. Dr. Jarboe found Claimant to be suffering from a pulmonary impairment which prevented his return to coal mine employment. Based upon the medical opinions of Drs. Dahhan, Baker and Jarboe, I find that total disability has been established pursuant to 20 C.F.R. §718.204(b)(2)(iv).

In the instant case, and when weighing all the medical evidence of record, I find that the pulmonary function testing and medical reports finding total disability are sufficient to outweigh the contrary medical evidence of record. Based upon same, I find that total disability has been established.

Causation of Total Disability

Having found that the evidence establishes that the Claimant has pneumoconiosis and total disability, next to be determined is whether his total disability is due to pneumoconiosis. Thus, in order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to the miner's disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3rd Cir. 1989).

As noted, Drs. Hudson and Jarboe do not find pneumoconiosis. Therefore, it is apparent that their medical opinions cannot establish pneumoconiosis as the etiology of Claimant's pulmonary condition. I also find, however, that their opinions cannot rebut the findings of Drs. Dahhan and Baker, that coal mine dust exposure is a contributor to Claimant's pulmonary disability. It should be noted that Dr. Hudson did not have the benefit of conforming pulmonary function testing, in rendering his opinion and indeed, was unable to determine the extent of Claimant's pulmonary condition. Dr. Jarboe relied heavily on the report of Dr. Hudson to render his own conclusions. By contrast, Dr. Dahhan was able to perform a complete physical examination which included lung volumes and diffusion testing in July of 1985. His opinion was that Claimant suffered from a disabling pulmonary impairment due in part to coal workers' pneumoconiosis. Dr. Baker also found total disability due to coal mine dust exposure. While Dr. Jarboe attempts to attribute Claimant's disability solely to cigarette smoking, that argument is not persuasive in light of the contrary medical opinions of record and in light of the greater number of years spent in coal mine employment than in cigarette smoking.

In sum, I find the opinions of Drs. Dahhan and Baker to be the more persuasive and based upon same, find that coal workers' pneumoconiosis is a substantially contributing factor to the Claimant's disability. Based upon their medical opinions, which I find to be the better reasoned and documented and therefore more persuasive, I find that total disability due to pneumoconiosis has been established pursuant to 20 CFR § 718.204(c).

## FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has met his burden to establish that he has pneumoconiosis and that he is totally disabled by the disease, he is entitled to benefits under the Act.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 CFR 725.503(b). Reviewing the evidence I do not find that the exact date of onset can be established. I therefore find the Claimant entitled to benefits from September 1, 2002, the month in which he filed his subsequent application.

Attorney's Fees

The Regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366. Claimant's attorney has not yet filed an application for attorney's fees. Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by H.M., JR. is hereby GRANTED.

William S. Colwell

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:pah

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).